MINUTES
HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES
Thursday, January 19, 2012
10:00 A.M.
Room 544 LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, January 19, 2012 in Room 544 of the Legislative Office Building. Representatives Torbett, Steen, Alexander, Avila, Boles, Current, Glazier, Hollo, and Randleman attended.

Representative Torbett presided. He gave a brief recap of the previous travel meetings across the state. Today we will be going over the suggestions from the information received from these meetings and today we will only deliberate the CON recommendations. Representative Steen welcomed everyone and expressed that the committee has received a lot of input and it was very informative.

Representative Torbett asked for approval of the minutes for October 6, 2011, October 20, 2011, November 1, 2011, and November 17, 2011. Representative Glazier made a motion that the minutes be approved. No discussion. Minutes were approved unanimously.

Member from the DHSR were introduced by Representative Torbett including Drexdal Pratt, Jeff Horton, Jessie Goodman, Craig Smith, and Chris Taylor. Subject matter experts in the audience may be called upon also.

Amy Jo Johnson, staff council, presented the power point presentation based on chart (see attached and on committee website). Research staff has gone through the presentations and the comments and put together a chart.

Rep. Torbett opened the floor for discussion.

Rep. Alexander: Could she speak and explain the organ transplant program.

Jeff Horton: Federal government put in new requirements for quality of care for each type of organ. We don't believe it is any longer needed to be governed under CON.

Rep. Alexander: How many hospitals are doing organ transplants?

Jeff Horton: We have 5 hospitals that perform those.

Rep. Avila: List which hospitals those are?

Jeff Horton: Carolinas Medical Center, Wake Forest Baptist Medical Center, UNC, Duke, and East Carolina.

Rep. Torbett: Would it be the recommendation of this committee that we do suggest to remove air ambulances and organ transplant from the CON process.

Rep. Boles: How does the FAA cover air ambulance?

Drexdal Pratt: Federal court ruling where there was a pre-emptions lawsuit against North Carolina and the federal court decided that was an FAA responsibility. It is part of other state regulatory requirements in the licensing piece, just not in the regulation as indicated in CON.

Rep. Boles: If a hospital wanted to put an air ambulance in, they would first have to get FAA approval and then come back and meet the state?

Drexdal Pratt: The FAA is just the air worthiness of the craft, the medical aspects of it is still regulated under our office of emergency medical services. Still requires a license, still requires affiliation with the county and affiliation now with a trauma center. Those are the state requirements that were not affected by the federal ruling.

Rep. Torbett: Let's formally address as a committee, is it the committee's decision to also have air ambulances stricken from the CON requests.

Rep. Glazier: Do you want a motion for the record?

Rep. Torbett: We can take it by consensus, or if you would like to formalize it in the form of a motion that would be fine either way.

Rep. Glazier: I move that we adopt the first recommendation that CON process no longer needs to and contain services of the air ambulance and solid organ transplant.

Rep. Alexander: I don't know how it's going to be written up or established, but it seems to me like those are similar, but they are different and so I just think that if you made it like separate, I mean when it is written, I would just like to make it a suggestion as making them separate, so it's very clear.

Rep. Torbett: Wishes of committee? Hearing no objections, Rep. Glazier since I got you to change your motion, would you like to separate that?

Rep. Glazier: I will do it in two separate motions. First motion is that the CON process no longer is needed for air ambulance services.

Rep. Torbett: Shawn has informed me that we will take it formally, but will of course bring the language back for adoption. We have a motion to have air ambulance stricken from CON process. All in favor say aye. Any opposition? Hearing none.

Rep. Glazier: Second motion that we remove solid organ transplant services from the CON statute as well.

Rep. Torbett: We have a motion on the floor. Any discussion? All in favor by the sound of aye. Any opposition? Hearing none. Next in your chart the diagnostic service center requirements under CON are difficult to enforce and rarely reported. I'm sure that this may have some more dialogue engage, but some options would be eliminate the diagnostic service centers from CON, increase the threshold amount, and eliminate clinical laboratories from definition. Comments from the committee:

Rep. Avila: Clarification, when we refer to these entities, exactly what are they?

Craig Smith: Diagnostic Center is defined in statute as a free standing facility program or provider including and not limited to physician's offices, clinical laboratories, radiology centers, and mobile diagnostic programs in which the total cost allowing medical diagnostic equipment over ten thousand dollars exceeds five hundred thousand dollars.

Rep. Avila: In the discussion there is the proposal to eliminate a clinical laboratory, what was the rationale for eliminating that versus a radiology unit or something of that type.

Rep. Torbett: Pretty much a cost driver. As we go through here you'll see that we have levels for application and in some opinions some of those levels need to be increased and I'm supposing the reason for this request, is that those are your less applicable needs to go through the CON process, so it would save both the process time as well as dollars for people applying those services.

Rep. Alexander: What would be an example?

Craig Smith: A clinical laboratory would be something like LAB CORP, which takes specimens collected at various physician's office and hospitals and processes these specimens. It's more of an industrial approach as opposed to the other services which are dealing one on one with the patient.

Rep. Avila: My concern is that when we start separating these things out, I know that hospitals have a lot of these, for instance, radiology departments and things of that nature and now we're just going to open it up and they can just pop up anywhere regardless of any evaluation of actual need in a community?

Craig Smith: That would be the result if it were eliminated totally, if the threshold were raised, they would still be subject to review, but with a higher threshold.

Rep. Boles: If you could elaborate on that, I think what I am hearing you say, they would still have to apply with the state and that you will still inspect them or some type of standards that they would still have to meet for the accuracy or be responsible for their reporting and equipment.

Rep. Torbett: If you will look down in your three bullet points, if you did the total elimination, then they would not have to apply. If you went with your second bullet point where we increase the threshold, then of course they would, but the dollars would be set at a higher level.

Rep. Boles: I don't have a problem with private enterprise and the threshold, I guess what I am asking that there would still be some type of oversight or some accountability, and I guess they still would apply with you.

Craig Smith: No sir. Unless one of these diagnostic centers is operated by another licensed facility such as a hospital in which it would be subject to the hospital standards. Diagnostic centers are not licensed by the State of North Carolina in that within the division of prevue, the division of health service regulation. Those that utilize radiation are regulated by the radiation protection section. Other services such as ultrasound and MRI scanners are not regulated by the radiation protection section. MRI scanners would still be subject to CON review because MRI scanners are listed in the statue specifically.

Jeff Horton: In clinical laboratories, if they were removed, our agency actually regulates clinical laboratories in terms of quality care and standards and we do that on behalf of the federal government. There would be regulatory oversight in terms of what they do in their performance and the tests they do and quality control measures in place. We're just talking about if they were removed from CON, that doesn't mean they just operate without any oversight. There would still be oversight from a quality of care perspective.

Rep. Alexander: So that includes the private facilities?

Jeff Horton: All laboratories in the state are covered under the clinical laboratory improvement amendments, which is a federal law. They have to have certificates and inspections by our agency.

Rep. Current: I received a letter of concern and I would like to have some of these experts speak to it for my own personal clarification. If a not for profit hospital is supposed to accept people whether they have any means of paying for their services or not, therefore, that hospital that has to treat than patient would use these diagnostic services to appropriately treat the patient. The concern that I've had raised to me is that if this were done, then a facility could come set up next door to the hospital and if the patients that showed up for their diagnostic services didn't have resources to pay, they would be rejected and sent to the hospital who would see them. This would, according to the people that contacted me, act adversely on the

diagnostic facilities of the hospital, in that they would end up primarily with the non-pay patients.

Craig Smith: Hospitals in the United States, if they are certified to participate in a Medicare program, they are covered under a law called the emergency medical treatment and labor act. Which means if you show up a hospital that is certified for Medicare, the hospital must screen you to see if you have an emergency medical condition and if you do, they must stabilize that condition? If you had a place that was not a hospital, such as a diagnostic center. The center could say we are not going to do any services for you here.

Rep. Current: The cost of healthcare is what we are all concerned about, we want quality healthcare at a cost that we can afford and it's pretty obvious that under the present scenario, the costs are increasing so that we are going to have a problem providing it. If we eliminate this CON of the diagnostic centers, what would end up in the cost of healthcare, as reflected, say in hospitals and so forth. Is there some way to get a grasp on that, and I think more importantly, the quality of care that ends up being delivered to the people.

Rep. Torbett: Rep. Current we are going to go on hold with your question, they have not been forgotten.

Rep. Avila: It's going to be obvious that what happens in a hospital, when they are losing money on diagnostic, they are going to have to up the price somewhere else in order not to go bankrupt. When you don't have a level playing field between one group and another group we've got to do some controlling and field leveling.

Rep. Glazier: I concur completely. The first option is not an option, it simply codifies cherry picking and I think that becomes a huge problem. I don't know enough about the second option and what the sort of variations of threshold options might be. I wonder if we could talk a little bit about that.

Rep. Boles: CONs are difficult to enforce and rarely reported. Does that mean that a lot of labs ask for permission to open?

Jeff Horton: A lot of little small labs would not be subject to the law, and again we regulate those. They have to have a CLIA certificate from us. We're all in the same division, we could call CON and say, did they get a CON for this big lab they just opened up and if they didn't, then the CON would stay stop it until you get a CON. The real problem comes with diagnostic centers, because we really don't have much regulatory oversight of those in terms of quality of care if they do just primarily imaging and some medical treatments. Those are the ones we don't know, there could be some out there that are operating that could be skirting the law and unless somebody in the community calls us up and says, I think this building exceeds the threshold for CON, we don't get many of those calls, we kind of figure there may be some out there, it's very difficult to regulate.

Rep. Hollo: How long has the $500,000 threshold been in effect and is there a recommendation to what it should be raised to.

Craig Smith: The threshold has been in place since March, 1993. Increasing cap to $1,000,000 would be reasonable.

Rep. Avila: Do we do any indexing to inflation, where they are evaluated on a regular basis or do we just have to statutorily look at them as legislature whenever somebody thinks about it and changes it.

Jeff Horton: For CON it is just set and there are not adjustments for inflationary increases.

Rep. Glazier: I wonder if staff could tell us, in other areas of the law, how we do indexing?

Amy Jo Johnson: There are other areas in the statute that discuss inflation.

Shawn Parker: There are statutory fees that are adjusted through the consumer price index.

Drexdal Pratt: In recent years we've seen the index drop and now it's rebounded, so that would add a bit of uncertainty.

Rep. Torbett: I understand those are annually under review, when the SHCC goes through their process.

Jeff Horton: It's under the prevue of the general assembly.

Rep. Glazier: I wonder if we could have any stakeholder's reaction to the suggestion of increasing the threshold.

Noah Huffstetler: The real problem here is the current definition of the way the threshold is calculated. If you are a physician's office, you might have $490,000 worth of major medical equipment as defined in the law that you have acquired over the last 20 years. You might buy a $12,000 microscope that would put you over the threshold to be a diagnostic and unwittingly you would therefore violate the law. There are numerous physician's offices around the state of North Carolina that have more than $500,000 in equipment that are in violation of the law right now and they don't know it. The way these things come to the attention of the government is when a member of the group gets dissatisfied or there is a disgruntled employee, they go and report the group to the CON section and say these people are violating the CON law. Change the way the threshold is calculated so that people can know they are subject to it or not and bring some clarity to it.

Rep. Glazier: How do we bring clarity?

Rep. Avila: Any loosening of this, we may be adversely burdening hospitals. I'd like to hear from the hospitals if there is an issue with this or if they some suggestions.

Rep. Torbett: I would like to pull this for further review and bring it back at a later date.

Rep. Boles: Talking about clarity does depreciation or anything built in over time.

Drexdal Pratt: The depreciated value of the equipment is not accounted for; it's the purchase price of the equipment.

Rep. Torbett: For staff, let's look at the cumulative cost of articles in an office and calendar time for that cost.

Rep. Avila: Could I have staff explain what effect of what deadlines would change or not change?

Craig Smith: Facilities write us from time to time, for determination that their project is not subject to review. Some of those are complicated, they are very close to thresholds and we want to evaluate whether anything has been left out of the proposal, also there are times that competitors comments on the veracity and legitimacy of the request. Right now there is no requirement in the law that the facility makes this request. If the facility honestly believes that it is not subject to CON, it can proceed with the development of a project, however, some prefer to get assurances that they may proceed, administratively and they submit requests. It is an informal process, the only time it is formalized is if the facility has a proposal, it has a certified cost estimate that the proposal is under $2,000,000 and upon initiating the proposal, finds out that they made an honest mistake and in that case the law provides that they can be forgiven and not penalized for proceeding with that project, providing they notify the agency. Exemptions in the statute 131.184 on require prior written notice; they do not require response from the agency as long as they meet the requirements in the notice. We do give them a response, but the response is not required for them to proceed. Material compliance requests can be complicated, where a project is being amended in some fashion, can still be developed without filing an amended CON application and because depending on the detail and the complexity of their request, it can take almost as long as reviewing an application, except this is done in an informal rather than formal basis, without a filing fee, without validity of a public hearing, and without a formal set of findings being developed.

Rep. Avila: Asking for forgiveness rather than permission?

Craig Smith: That is not the case.

Rep. Avila: Since it is on here, I'm assuming it is a problem for somebody.

Rep. Torbett: We will put this on hold and find out where this originated and bring it up at our next discussion.

Rep. Glazier: Move that we adopt the recommendation that we direct the agency to accept or to require electronic forms and make appropriate modifications to the statute for electronic submission, I say that just to know if there is opposition to that, what it is?

Rep. Torbett: I agree, but I would like to see cost associated with implementation.

Rep. Avila: I would like to second that, with caveat that we look at cost.

Rep. Boles: When the hard copy is submitted now, it still has to be put on line for review?

Drexdal Pratt: The applications that we receive a voluminous. We have had much discussion about this and we are in the process of putting in a new electronic system that handles some of our processes. There is going to be cost associated with this, because there are so many attachments and you are getting into file size issues.

Rep. Boles: When they do make the application, do you put it on line?

Craig Smith: No it is not. It is made available for inspection. It would consume a lot of staff time for us to scan all the applications. There was a recent review in Wake County for nursing home beds. We received 16 applications. All the applications and attachments fill up two carts, stacked more than a foot high on both top and bottom layer.

Rep. Torbett: It is probably going to go on our list to look at refinement and reducing the amount of information needed.

Rep. Avila: You receive it in paper format. There are no electronic submission capabilities for your department?

Craig Smith: We have accepted an additional copy on CD of the application. We do need a paper copy to work with.

Drexdal Pratt: We are having discussions about that, because when you are talking about limiting the size of the fields if we do an online application, we would have to limit the characters that people could enter the data, and all sorts of things. This one is rather unique and will take some time to do if directed to do that.

Rep. Avila: Maybe we should defer to the department and let them finish their study. Streamlining applications might be something that we could look at.

Rep. Torbett: I concur and I just add that with an official recommendation from this committee addressing their advancements in this, specifying for directing it to the CON process for application, I think would be appropriate language coming from this committee. Even though

they are working on it, but in all specificity it says, you will look also at the CON submission process, which is also a great Segway in our second one on page 2.

Rep. Glazier: I agree with what the chairman and Rep. Avila are saying and understand the cost and time. By the same token, when the section is looking at moving this way, I think it would very helpful for us to have a recommendation in the report that indicates they ought to be talking as well to the applicants about what their needs are on the input side of this.

Rep. Torbett: Would it be the feeling of this committee that applications being submitted would be a recommendation?

Rep. Alexander: They have to have some in print, what are their needs.

Rep. Torbett: Mr. Pratt, was it in your scope in bringing some of this in electronic form, is that in your current list of to dos?

Drexdal Pratt: We have had discussions and we are in the process of having a system wide electronic processing program put together now.

Rep. Torbett: No time line has been determined, would be appropriate that we recommend a time line.

Drexdal Pratt: We have discussed posting our decision on line.

Rep. Glazier: What is the logistic or downside to posting the decision on the website?

Craig Smith: We have one person who is our web person and they do other jobs as well. Do we have the staff time and resources? I don't think we actually need statutory direction.

Rep. Glazier: Because I view a decision as a legal document that may be numbers of pages in your case, I've had to read long CON decisions, but still it is a typed document of decision, so not a hard document to transfer. How many on average, a month, decisions are issued?

Craig Smith: Last year we received 144 applications. On average it would be 12 decisions a month.

Rep. Glazer: I just think from a public point of view and transparency point of view, the one thing we ought to make sure is on the website is the final decision by the agency and to the extent that more resources are needed to assist in doing that, I would think that would be something we would want to do.

Rep. Avila: They are typing this up and it is a word document that you can convert into a PDF and download pretty quickly, I wouldn't think there is a significant additional necessary time fact that would be impacted.

Rep. Torbett: We would recommend that they require electronic submissions of applications, they require all application determine requests, requests for review, as well as agency decisions to be posted on the website.

Rep. Glazier: I was focusing only on the decision.

Rep. Torbett: Recommend that the final decision is posted on the website? No opposition. Recommendation that they would bring back costs associated with application requests be online?

Rep. Glazier: Recommend as to applications is to move with all deliberate speed to develop a system for being able to post online.

Rep. Avila: Some of these requests are complicated; would we have to be a little judicious in those as well?

Craig Smith: There are not as long as applications in most cases. A short application is close to 100 pages.

Rep. Torbett: I am going to pull this and hopefully by meeting in February can you give more specifics on going online and bring costs.

Rep. Avila: Could there be a consideration of having public comments to be posted as well.

Craig Smith: We post the comments that are submitted during the comment period to the website now.

Rep. Avila: I talking about letting people post to your website, comments, if they are unable to attend in person.

Craig Smith: We will have to look into logistics of that.

Drexdal Pratt: They have to send it in, we don't have the ability to have an online update by the individual, but we do take those comments, scan them, and put them on the web.

Craig Smith: The law specifies written comments are to be made within the first 30 days of the review period. Then it specifies the public hearing will be held 20 days after the comment period.

Craig Smith: We looked at the cost, we went to the federal department of labor statistics and looked at the cost of the increasing construction since 1993 and the cost of medical and hospital and one had gone up 71% higher, the other was 76% higher. We multiplied that out and took into consideration that if there were going to be a statutory change, the statutory

change might not take place for approximately 6 months, so we felt that doubling the cost of $2,000,000 to $4,000,000 was reasonable and on the next issue the $750,000, I believe we raised that the 1.5 million for major medical equipment. The expedited review we felt the threshold of $5,000,000 should be raised to at least $10,000,000 if not eliminated entirely. Replacement equipment threshold is now $2,000,000 and we had talked about raising that to $3,000,000, $5,000,000 or possibly eliminating it entirely.

Rep. Torbett: What impact do you think these changes would have on the department by reducing CON requests?

Craig Smith: There were 20 applications over the last three years solely based on cost, we looked at the fees that would have been foregone, that would have been about $70,000 or so a year. It would reduce the applications by about 7 a year.

Rep. Avila: Does this just affect the process or does this affect the people in terms of what kind of issues may be raised when the threshold changes.

Jeff Horton: Some of your larger hospitals, if you were to double it to 4 million, many times when they do a major renovation, they are going to be over the 4 million anyway, so I doubt if it really would affect them. Some of the smaller providers, the law was changed a couple of years ago to allow nursing homes, adult care homes, and intermediate care facilities of the mentally retarded to be exempt from this threshold if they are doing a replacement facility or renovation to improve the quality of life or quality of care for the resident, so it really wouldn't affect them. There could be some smaller providers that might be exempt. For the big providers, it probably would have little effect, for the medium size providers it probably would have an effect where they would not have to file a CON application. From our workload standpoint, we would see a little reduced revenue.

Rep. Avila: Are they restricted in what they can do if they do not exceed the threshold?

Jeff Horton: Depends on what they wanted to add. They would not be able to add beds, some major medical equipment they would not be able to add.

Rep. Torbett: When was the current threshold put in place?

Craig Smith: March 1993.

Rep. Glazier: I was curious since this recommendation is coming from the agency; is there any objection by any stakeholders?

Rep. Torbett: Any objection from any stakeholders here?

Rep. Glazier: I would make a motion to increase the monetary threshold for projects requiring a CON under 131.176 to 4 million dollars and make confirmatory changes to section 176.16 and section 131.184.

Rep. Torbett: Committee in favor? All in favor, no opposition.

Rep. Torbett: Monetary threshold for expedited review, why does the department feel it could be eliminated?

Craig Smith: Expedited review as defined in the statute includes reviews which are non - competitive, reviews in which the public has not requested a public hearing, or reviews in which the agency has determined a public hearing is not in the public interest. The other threshold is monetary. The expedited review in addition to focusing on a quicker turn around also focuses on the ability of the department to work with the proponent of the project to modify the application in such a fashion that it could be approved. These tend to be non –controversial projects. The only down side would be if we get overwhelmed by requests then scheduling does become a bit more problematic because we can only extend the review if we need substantive information. For many projects, such as the one the gentleman from South Port spoke about, where it is over 10 million dollars and it is a renovation of a hospital. We have to hold a public hearing. If we were to raise the threshold, it would still be covered by the threshold, but it would allow us to work with somebody if there were insufficient documentation in one area. The other alternative is to deny the application, have the party appeal, and then work out a negotiated settlement, which takes more time and puts more burdens on the applicant.

Rep. Avila: When it talks about request for a public hearing is not received in a specific time frame, are expedited reviews published so that people know that they are out there to make a request for public hearing.

Craig Smith: All applications received, we publish legal notice.

Rep. Glazier: Any stakeholders can let us know if there is opposition and why?

Rep. Torbett: Anyone in the audience wishing to speak? No one.

Rep. Glazier: I move that we adopt the recommendation to eliminate the monetary threshold for expedited review and make conforming changes to 131.176 7BB and 131.181A12.

Rep. Torbett: Committee in favor? All in favor, no opposition.

Craig Smith: Major Medical equipment threshold from $750,000 to 1.5 million.

Rep. Glazier: Any objection by stakeholders to raise the threshold?

Chip Baggett from NC Medical Society: We're paying close attention to your recommendations, but you are asking a lot of very fair questions, Rep. Glazier and we're not prepared to answer those questions today. Just because we are silent doesn't mean we don't want to come back and have a further conversation with you later on.

Rep. Avila: I would like to make the motion that we raise the monetary threshold to 1.5 million dollars and make conforming changes to 131.176 14O.

Rep. Torbett: Committee in favor? All in favor, no opposition.

Rep. Alexander: I believe I heard 3 or 5 threshold for replacement equipment?

Craig Smith: 3 million would be a 50% increase, somewhat less than inflation, but it would be double the cost of major medical equipment, that was the rationale. 5 million was to make it more open ended, given that the facility had already been operating the equipment for some time and in most cases demonstrated a need for it. We also discussed the possibility of eliminating the threshold altogether, I'm a little dubious on that because I am not sure if someone who has a 2 million dollar piece of equipment and they come out with a 15 million dollar piece of equipment that can do the same thing but with a little bit more, is it worth someone getting it without review.

Rep. Hollo: Technology is changing rapidly in the medical field. A machine you buy today could be obsolete two years from now. Since they had a CON for the original equipment and are using that type of equipment, why would you ask them to go back and get a CON for the same equipment just because they are replacing that piece of machinery? I would be more in favor of eliminating it.

Rep. Glazier: I would go with the 5 million. What is the definition in the statute of replacement?

Amy Jo Johnson: It is defined as equipment that costs less than 2 million dollars and it is purchased for the sole purpose of replacing comparable medical equipment currently in use, which will be sold or otherwise disposed of when replaced.

Rep. Glazier: Any objections by stakeholders to raise threshold?

Rep. Avila: Due to technology, the machine could be doing other things than what it was originally intended for. Opens an area of expansion potential.

Amy Jo Johnson: It just uses the word equipment.

Rep. Hollo: Technology changes continuously. Example of CT scanner, its measured on slices and how good of a picture they can get and that is constantly changing. I would like to put the Hospital Association on the spot and hear from them.

Hugh Tilson, NC Hospital Association: I would like to reserve the right to come back with further information after we have seen the specific things that you are talking about. Many CON regulated items occur in the State Medical Facilities Plan, and therefore, there is a need determined for those and there is a competitive process for which they would be awarded. Some aren't. So the only concern that pops into my mind about having a threshold is that if it is a CT scanner or something like that you get under the threshold right now and then come back later for an upgrade, then it is not necessarily potentially subject to the same degree of scrutiny that something like a linear accelerator would be under.

Rep. Glazier: Would you be willing to put this one on hold and get the comments back and make a decision at the February meeting?

Rep. Torbett: We will hold this back with the other ones. If you have additions or questions on upcoming meeting please forward to chairs or staff.

Rep. Avila: In terms of the COPA, it is different from the CON, currently there is a lot of flexibility for what can happen under the COPA, we're talking about making changes and modifying it, would we be prudent in saying ok let's not do anything going forward, until the recommendations are in place, because something may happen that goes beyond what we want to recommend and turning back the clock or moving backwards in action may be more difficult than we can handle.

Shawn Parker: The work you did today was giving direction on what recommendations you may make. In a House Select Committee their step one would be to identify recommendations that the committee is comfortable with and then make a recommendation to the body as a whole, so as far as step one, even today's action will require follow up action from this committee to actually approve a report to the general assembly, which can contain legislation or other recommendations that may not have direction, that are just recommendations to set what the intent of this committee was, so I think that would still be the case, if you have discussion in the next meeting on COPA in the similar manner as this, it does not bind this body or even this committee as to what actions it is going to take or recommend as a final product of your work and your direction.

Rep. Boles: When we meet next, with the COPA, I understand the Attorney General's Office has concerns, will that be addressed?

Rep. Torbett: I have not heard from them specifically, but by all means there concerns are brought forward.

Rep. Current: This information may be already available, but it seems I'm getting conflicting things from here to there, could you or staff get me a report that demonstrates, unequivocally, the states that have CON, their percentage increases in the cost of health care versus the states that do not support a CON and their increases or decreases in the cost of health care.

Shawn Parker: We have access to Kiser Family, there are state data reports, and unfortunately, sometime beyond the time frame they have had to collect the information may be from 2005, but there are other definitions when you measure health care costs, so we are limited as to what they have identified as far as in ratings. The more sources we seek, and then there is a possibility that there is some conflicting date, just as how it was measured and analyzed from the different sources.

Rep. Steen: One clarification. This committee does have subpoena power if we do need that, is that correct staff?

Shawn Parker: Yes, that is part of this committee's powers.

Rep. Steen: As far as the COPA, I think we would like to be fair to both medical facilities there in the western part of the state, the COPA is a very complex issue and I think we want to take it very diligently and look at all sides of this thing. One question that I think we are getting on the committee is what happens if the COPA goes away. What does that mean to Mission, what does that mean to Park Ridge and other facilities in the area? I think we should go slowly and have appropriate staff here with DHSR and maybe someone from the Attorney General's office. We will make sure we hear from both sides and all sides.

Rep. Boles: In getting back to the IT issues, if I'm correct there are 39 states that have CON, or 37, I don't think we are going to invent a new wheel about the IT issues. It would be interested to see if other states are more online.

The Committee adjourned at 12:00 p.m.

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Representative John Torbett, Co-Chair, Presiding Viddia Torbett, Committee Clerk

Representative Fred Steen